mobile endodontic associates

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CONFIDENTIAL INFORMATION QUESTIONNAIRE
PLEASE FILL OUT FRONT AND BACK COMPLETLEY AND SIGN

Name: _____ prefer to be called _____

General Dentist:_____ Referred by: _____

[ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Partnered [ ] Child [ ] Widowed [ ] Divorced [ ] Separated

Birthdate:___/___/____ S.S. # _____

Home Address: _____ City_____ State_____ Zip _____

Home Phone: (____)_____ Work: (____)_____ ext._____ Cell: (_____)_____

E-mail Address: _____

Employer: _____ Occupation: _____

Dental Insurance Information

Primary Insurance:

Insurance Co. Name:_____ Phone: (____) _____ Group/Policy # _____

Insured's Name:_____ Insured Birth date: ____/____/____ Relation_____

Insured SS#:_____ Contract # or I.D. # (off Insurance card): _____

Secondary Insurance:

Insurance Co. Name:_____ Phone: (____) _____ Group/Policy # _____

Insured's Name:_____ Insured Birth date: ___/___/___ Relation_____

Insured SS #:_____ Contract # or I.D. # (off Insurance card): _____

HIPPA

Acknowledgement of Receipt of Notice of Privacy Practices & disclosure of Health Inform

Please sign stating that you are aware and have received this office's Notices of Privacy Practices and disclosure of health inform. If you would like a copy, brochures are located at the front desk for your convenience.

Please Initial here: _____**Date:** _____

Non-Surgical Consent Form

I have read and understand all the contents of the Consent for Non-Surgical Endodontic Treatment form. All of my questions have been answered. I understand that I can request a copy of this form for my records.

Please Initial here: _____**Date:** _____

Medical History Information:
Do you have or have ever had any of the following? Please check those that apply:

- ☐ Asthma
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hepatitis A, B, C, other
- ☐ Seizures/Fainting
- ☐ Abnormal Bleeding
- ☐ Cancer
- ☐ HIV(+) /AIDS
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Are You Pregnant?
- ☐ History of Chemical Dependence?
- ☐ Ulcers/Digestive Conditions
- ☐ Migraine/Headaches
- ☐ Mental/Neural Conditions
- ☐ Tumor/Neoplasms
- ☐ Alcoholism/Addiction
- ☐ Infectious Disease
- ☐ Venereal Disease
- ☐ Psychiatric Care
- ☐ TMJ
- ☐ Prosthetic Implant
- ☐ Any Transplants? Type: _____
- ☐ Joint Replacement

☐ Any other medical conditions not listed above? If yes, please list:
_____

Do you need to be pre-medicated with antibiotics for any medical condition (such as MVP, artificial joints, etc.) before receiving dental treatment? ☐ Yes ☐ No

Allergies: Please check those that apply

- ☐ Latex (Rubber products)
- ☐ Aspirin
- ☐ Penicillin
- ☐ Novocaine (or other local anesthetic)
- ☐ Codeine
- ☐ Sulfa
- ☐ Any other foods or drugs? Please list:
  _____

Medications:
Do you take **blood thinners**? ☐ Yes ☐ No

Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax, or Zometa within the last 12 months? ☐ Yes ☐ No

Are you taking any medications, vitamins, or herbals? ☐ Yes ☐ No
If yes, PLEASE LIST ALL: _____
_____
_____
_____

INFORMATION TO OUR PATIENTS

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. Please feel free to discuss the treatment or the fee at any time with us.

When endodontic therapy is complete, your tooth will require a permanent restoration. OUR FEE DOES NOT INCLUDE THIS SERVICE. Your general dentist will render this service for the preservation of your tooth. You should make this appointment with your general dentist as soon as possible upon completion of root canal treatment.

Patient Agreement

I understand that root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

We provide your dental care. Our relationship is with you and not your insurance company. Your insurance is a contract between you, your employer, and your insurance company. This office is not a party to that contract. While the filing of your insurance forms is a courtesy that we extend to you, all charges are your responsibility.

Please sign here: _____ Date: _____

Covid-19 Treatment and Notice and Acknowledgement of Risk: Initial here:_____

There is an additional fee of $65.00 for nitrous oxide sedation (laughing gas). Dental insurance will not pay for this service. If you would like to receive nitrous oxide sedation as part of your treatment, please initial here: _____